COLORECTAL CANCER

A Risk Management Guide for Health Care Professionals

INTRODUCTION

Colorectal cancer is a preventable disease and is almost always curable when detected early. However, because of low screening rates, it is not usually diagnosed at the earliest, most treatable stage [see figure 1]. Consequently, it remains the **leading cause of cancer death** among nonsmoking Americans.

As a primary care provider, you play a key role in motivating your patients to participate in routine colorectal screening. Even though they might feel embarrassed about it or find it inconvenient, **most patients will have the test if you recommend it**. In a recent Massachusetts survey, people were much more likely to be up-to-date on screening if their physicians had recommended the screening (*Am J Prev Med* 2002;23:28-35).

CURRENT SCREENING GUIDELINES

Colorectal cancer screening should begin at age 50 for average-risk individuals. The purpose is twofold: 1) to find and remove adenomatous polyps, thus preventing colorectal cancer, and 2) to detect colorectal cancer early. Although the incidence of invasive disease is low at age 50, about 25% of adults this age will have adenomatous polyps.

Virtually all authoritative groups, including the American Cancer Society (ACS) and U.S. Preventive Services Task Force, now recommend five options for screening average-risk individuals. The ACS screening options are:

- Fecal occult blood testing (FOBT) every year
- Flexible sigmoidoscopy every five years
- Annual FOBT plus flexible sigmoidoscopy every five years
- Double-contrast barium enema every five years
- Colonoscopy every ten years

RISK MANAGEMENT

Having multiple options for colorectal cancer screening gives physicians and patients some flexibility. However, it also creates debate over which option is best, leading some physicians to choose not to screen. This is unacceptable. It is the physician's responsibility to inform patients of the need for screening, to conduct or arrange for screening tests, and to follow up on all test results.

Colorectal cancer screening is now the standard of care, and from a risk management perspective, it is difficult to defend physicians who fail to meet this early detection standard [see figure 2]. To help primary care providers manage their risk with respect to colorectal cancer screening, two medical malpractice insurers, ProMutual Group and Risk Management Foundation of the Harvard Medical Institutes, have outlined the steps on the reverse side of this page.

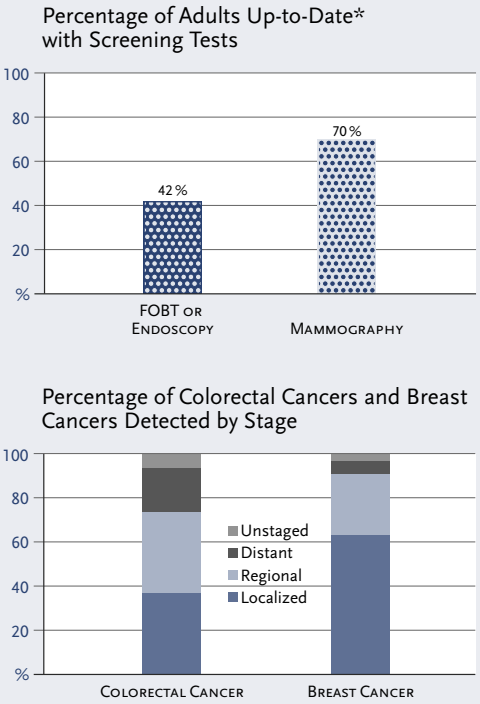

Figure 1

Colorectal cancer screening tests are used less frequently than breast cancer screening tests. As a result, colorectal cancer is often diagnosed at a later stage, even though effective screening tests are widely available.

*Up-to-date is defined as FOBT within the past year, lower endoscopy within the past ten years, and mammography within the past two years.

Sources: Ries LAG, Eisner MP, Kosary CL, et al (eds). *SEER Cancer Statistics Review*, 1973-1999, National Cancer Institute. Bethesda, MD, 2002. **http://seer.cancer.gov/csr/1973_1999/**; National Health Information Survey 2000.

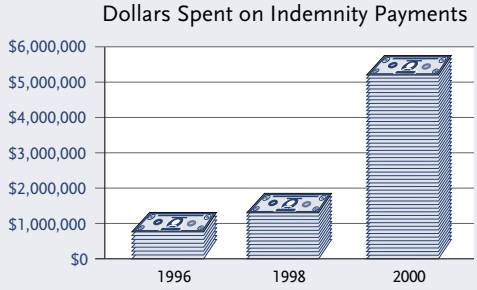

Figure 2

As a medical malpractice insurer, ProMutual Group has seen an escalating number of claims related to failure to diagnose colorectal cancer. Concurrent with the rise in claims is a staggering increase in the aggregate amount of indemnity payments.

Source: ProMututal Group. *Perspectives on clinical risk management*. Winter 2002.

RISK MANAGEMENT CHECKLIST

1 DEVELOP A COLORECTAL CANCER SCREENING PROTOCOL.

Although there are multiple formats and pathways for such a protocol, the key is for each practice to **choose one protocol and adhere to it**. The protocol should be written and distributed to all clinicians and staff in the practice.

2 OBTAIN A CANCER-SPECIFIC FAMILY HISTORY.

Patients who have a first-degree relative with colorectal cancer are at increased risk of the disease and need earlier screening, particularly if the relative was diagnosed before age 60. In many malpractice cases, the primary care provider did not learn of the patient's family history until long after the patient became symptomatic.

3 IDENTIFY THOSE AT RISK.

Patients with the following factors have a higher-than-average risk of colorectal cancer and should be screened earlier and more frequently than others:

- Personal history of adenomatous polyps or colorectal cancer
- Family history of colorectal cancer or adenomatous polyps in a first-degree relative
- Specific genetic syndromes, including familial adenomatous polyposis and hereditary nonpolyposis colorectal cancer
- Inflammatory bowel disease (Crohn's disease or ulcerative colitis)

Symptoms

Primary care providers should carefully evaluate **all** symptoms of colorectal cancer, including **rectal bleeding**, **abdominal pain**, and **changes in bowel habits**. In a significant number of malpractice claims, providers incorrectly assumed that rectal bleeding was due to hemorrhoids.

4 DEVELOP A REMINDER SYSTEM.

It is **not** the patient's responsibility to request a screening test. Primary care offices need to have a reminder system or tickler system to let patients know when a test needs to be scheduled. The system should also make some provision for follow-up if the patient fails to respond to the first reminder.

5 DOCUMENT TESTS OFFERED.

It is important to document every screening and diagnostic test that is offered to a patient, as well as whether the patient complies. Such documentation can help avoid a round of "he said, she said" at a later time.

6 DEVELOP A TRACKING SYSTEM.

Primary care offices need to have a system in place for tracking the completion of colorectal screening tests, for example, the return of FOBT cards. Some physicians feel such a system is too cumbersome to implement. However, if the measure of a system's usefulness is its ability to prevent even one claim or suit, a tracking system should be a necessary part of a comprehensive risk management strategy.

7 FOLLOW UP ON ALL POSITIVE TESTS.

It is not adequate to dismiss one guaiac-positive stool as an aberration or to assign it a benign cause without performing the proper diagnostic evaluation. A number of malpractice cases could have been prevented if physicians had considered the possibility of cancer and performed appropriate follow-up tests.

The Massachusetts Colorectal Cancer Working Group is committed to reducing the burden of colorectal cancer through education, prevention, early detection, advocacy, policy, and research. Members include the American Cancer Society, Boston Medical Center, Dana-Farber Cancer Institute, Exact Sciences Corporation, Harvard Center for Cancer Prevention, Massachusetts Nurses Association, MassPRO, ProMutual Group, Risk Management Foundation of the Harvard Medical Institutes, University of Massachusetts Medical School, and others.

Additional Resources

- The American Cancer Society guidelines describe screening protocols for high-risk patients and proper follow-up of abnormal tests. Full text is available in *CA: Cancer J Clin 2001;51: 38-75*. This journal is available at **http://www.cancer.org** or by calling **800-ACS-2345**.
- The Agency for Healthcare Research and Quality has produced "A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach." Full text is available at **http://www.ahrq.gov/ppip/manual/**.
- The U.S. Preventive Services Task Force updated its colorectal cancer screening guidelines in July 2002. Full text is available at **http://www.ahcpr.gov/clinic/3rduspstf/colorectal/**.